DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1011 (Rev. 08/05)

STATE OF WISCONSIN
HFS 107.31(2)(b), Wis. Admin. Code

WISCONSIN MEDICAID
PHYSICIAN CERTIFICATION / RECERTIFICATION OF TERMINAL ILLNESS

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

If a verbal certification is obtained within two calendar days after the initial six-month period of care begins, the hospice has up to eight calendar days after the six-month period begins to obtain a written physician certification of a recipient's terminal illness. If the physician's written certification is not obtained within eight calendar days, only services provided on or after the signature date of the physician's certification are reimbursed.

Provision of the information requested on this form is mandatory. However, the use of this version of the form is voluntary. Providers may develop their own version of this form as long as it includes all the information on this form.

Instructions: Type or print clearly. Keep this information in the recipient's records; *do not* send it to Wisconsin Medicaid.

SECTION I — CERTIFICATION STATEMENT

Name — Recipient	Recipient's Medicaid Identification Number

Description of Disease

We (or I) certify that the above-named Medicaid recipient is terminally ill with the disease described above. His or her life expectancy is six (6) months or less if the disease runs its normal course.

SIGNATURE — Hospice Medical Director or Designee	Certification Date

SIGNATURE — Attending Physician	Certification Date	Medicaid Provider Number	Date Signed

SECTION II — RECERTIFICATION STATEMENT

I recertify that the above patient is still considered terminally ill with the above-stated disease and has a life expectancy of six (6) months or less if the disease runs its normal course.

SIGNATURE — Hospice Medical Director or Designee	Recertification Date	Date Signed

Reset Form